

## **Waiver Request Item: STOP – Sobering Treatment Opportunity Program**

### **Overview**

Persons with “Chronic Alcohol Dependence” are a major source of emergency room utilization. First responders (e.g. police, fire, and rescue) are required to bring inebriated people to hospital emergency rooms if they are not in police custody for committing a crime. The State of Rhode Island is requesting authority to provide Medicaid beneficiaries who have a dependency with a program of integrated supportive services provide in specialized settings. This program, called the Sobering Treatment Opportunity Program (STOP), provides a combination of short-term recovery services, assessment for detoxification treatments, transitional supports, and/or referral arrangements. As the range of potential STOP settings can be quite variable, the State is seeking the flexibility to consider any offering Medicaid beneficiaries the appropriate mix of cost-effective core and ancillary services and the support of highly trained professionals (e.g, health care practitioners, sober coaches/peer specialists, navigators, etc.).

On an operational level, STOP functions as an emergency diversion program. Beneficiary participation begins only after a pre-admission clinical and functional assessment has been performed and the Medicaid beneficiary is determined appropriate for the program. Screening to identify potential mental health issues also is performed, when appropriate, using an evidence-based suicide/mental health assessment tool. In the STOP model, licensed clinical staff are available on-site to monitor clinical issues and facilitate transfers to a hospital whenever a higher more intensive level of care is necessary. Peer specialists will be utilized to help engage beneficiaries and guide them through the steps of participation, recovery, and ongoing support services in the program. Length of stay in the initial phase of STOP will typically be 48 to 72 hours, with additional time for detoxifications and transitional services.

Once a beneficiary has safely progressed from the immediate incident initiating contact with STOP, the beneficiary will be referred by the center staff for detoxification, a transition program, and outpatient and/or residential treatment. The STOP peer specialist/sober coach conducts the appropriate follow up to coordinate appointments for the Medicaid beneficiary, assist with keeping appointments and in making arrangements for temporary, supportive, and/or permanent housing and employment. Upon discharge, the State plans to provide rewards to beneficiaries who continue with treatment and a plan of self-recovery.

### **Target Population**

STOP will be available to adult Medicaid beneficiaries who are chronic inebriates.

### **Waiver Authority Sought**

The state seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope in order to offer STOP only to individuals identified as chronic inebriates and in a setting approved specifically to facilitate the program's purposes. The State is also requesting authorization to use member incentives --such as vouchers for food, housing, or clothing -- to encourage and reward beneficiaries who continue treatment upon discharge from STOP

This amendment request seeks to modify paragraph 32 of the current STCs by adding a new subparagraph authorizing the State to provide STOP services to any Medicaid beneficiary who meets the applicable clinical criteria regardless of delivery system enrollment.

### **Rationale**

Providing access to STOP has the potential to reduce Medicaid expenditures for high cost emergency room visits and hospitalizations. More important, STOP aligns with our guiding principle of Prevention and Wellness: to provide consumers with individualized health care that is outcome-oriented and focused on prevention, wellness, recovery, and maintaining independence. Medical stabilization and access to integrated health care services through STOP will thus not only lower utilization of costly publicly-funded services, but promote better overall health in the short-term and overtime. For example, assistance in accessing transitional housing that supports lifestyle change until beneficiaries can access residential treatment and, eventually, permanent housing, will help reduce homelessness and incarceration. These improvements in the quality of life of beneficiaries will delay or avert the need for long-term services and supports, reduce instances of at-risk behaviors and, as result, lower State and federal expenditures on health care, human services, and criminal justice.

## **Waiver Request Item: Telemedicine Services**

### **Background**

The State of Rhode Island seeks to federal authorization to make telemedicine services available to Medicaid beneficiaries for the remainder of the waiver. extension period. Telemedicine is the use of telecommunication and information technologies in order to provide clinical health care at a distance through the use of video links, e-mail, telephone, or another telecommunications system to transmit medical information, e.g. in consultations between a beneficiary and patient.

The use of telemedicine is a cost-effective intervention in situations when routine monitoring, care management and supports are integral to maintaining and optimizing health and face-to-face interactions between beneficiary and health care professional are prohibitively expensive. Telemedicine also provides the opportunity for expert clinicians to use technology to assist other licensed professions remotely when evaluating and treating beneficiaries during routine and emergency procedures. Accordingly, interactive telecommunication can achieve improved health care management, monitoring, and outcomes, enhancements in evaluation and treatment, and significant Medicaid cost-savings. These costs can be reduced without compromising the professional and medical standards of the customary office visit/consultation and decrease unnecessary emergency department visits, ambulance runs, and other transportation expenses.

### **Target Population**

Medicaid beneficiaries, including recipients of long-term services and supports, without regard for service delivery mechanism.

### **Waiver Authority Sought**

EOHHS requests a waiver of section 1902(a)(10)(B), amount, duration, and scope in order to enable the State to offer telemedicine services to all Medicaid beneficiaries.

This request seeks to modify paragraph 26 of the current STCs to stipulate that telemedicine services are available to a Medicaid beneficiary when medically necessary irrespective of delivery system enrollment.

### **Rationale**

Telemedicine services have been used effectively and successfully in states across the nation for over decade and for a wide variety of purposes. Medicare now covers telemedicine services for elders and persons with disability who are in need of intensive case management and monitoring. Over the last three years, legislators in Rhode Island have proposed bills mandating coverage of telemedicine services and/or inclusion of such services as an essential benefit. All of these developments are indicative of a growing consensus about the benefits and inevitability of telemedicine. The use of telemedicine for Medicaid beneficiaries will maximize the State's

effective utilization of information technology systems to address disease, enhance stabilization of chronic conditions and promote health and independence across settings.

**Waiver Request Item: Peer Specialist**

**Overview**

The State of Rhode Island requests the authority provide the services of highly qualified peer specialists to Medicaid beneficiaries with certain chronic diseases and conditions. A peer specialist is a credentialed health care professional who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connectedness to the community. When providing these services and supports, the peer specialist does not serve as a substitute for other practitioners, but as part of a multi-disciplinary team. The role of the peer specialist is to bring to the beneficiary the unique vantage point and skills of someone who has succeeded in managing a serious behavioral health condition or developmental disability or has lived addiction and recovery or bouts of homelessness. A peer specialist also can be a loved one, family member or friend who has shared in these experiences with a person directly affected.

The use of peer specialists has occurred most frequently in the behavioral health arena and specifically for persons with dependency issues or serious mental illnesses. These peer specialists (peer recovery specialist or PRS) typically work under the direction of a licensed health care practitioner or care manager or coordinator. In addition to providing general care supports, the peer specialist utilizes his or her own experiences to act as a role model, teacher and guide who both encourages and empowers the beneficiary to succeed. The PRS assists the beneficiary in a variety of unique ways ranging from articulating service preferences and needs to identifying and evaluating affordable housing options, and on to teaching coping and self-advocacy skills.

Specific other examples of PRS work include, but are not limited to, the following:

- Supporting individuals in accessing community-based resources, recovery, health and wellness support, and employment services;
- Guiding individuals in developing and implementing recovery, health and wellness, and employment plans;
- Serving as a role model for the integration of recovery, health and wellness, and employment;
- Educating individuals regarding services and benefits available to assist in transitioning into and staying in the workforce;
- Navigating state and local systems (including addiction and mental health treatment systems);
- Mentoring individuals as they develop strong foundations in recovery and wellness;
- Promoting empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences;
- serving as an integral member of an individual's recovery and wellness team

Peer Recovery Specialists may be employed as part-time or full-time staff depending on agency capacity and community needs. Providers often employ more than one PRS within an agency and use peers to build agency service capacity. It is not unusual for PRS to take on more proactive roles in the recovery process as they gain experience. To ensure PRS provide culturally relevant services, agencies try to match peers with beneficiaries who share the lived experience, culture, ethnicity, health and behavioral health service experiences of the people with whom they will work.

In sum, PRS services are a critical component of the continuum of care and, as such, play an important role in optimizing health and delaying the need for high cost acute and long-term institutional-based care for Medicaid beneficiaries. For this reason, Rhode Island plans to incorporate a PRS model into the Medicaid program as part of broader effort to provide beneficiaries better, and more person-centered services.

The State will require PRS participating in Medicaid to obtain certification to ensure they are properly qualified. To be a certified in the State, a prospective peer specialist must meet the following criteria:

- Diagnosed with mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and have received treatment for that diagnosis or is currently receiving mental health, addiction, physical health or, I/DD services or have lived experience with a family member or loved one with one of this experience. Individuals who have undergone periods of homelessness may also apply for this credential. Further, they must be willing and able to share their lived experience with those who have similar life issues
- Credentialed by the Rhode Island Board for Certification of Chemical Dependency Professionals (RIBCCDP) as a Peer Recovery Specialist. RIBCCDP credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC).

Peer Recovery Specialists certified through this process will be qualified to provide non-clinical, person-centered, recovery-focused support.. The service levels provided will be determined on an individual basis taking into account the intensity of the beneficiary's situation and the experience of the Peer Recovery Specialist. Peer Recovery Specialist services include a range of activities that are delivered in community settings. The location where peer services are provided will be flexible based on the need.**Target Populations**

Medicaid beneficiaries with behavioral health, physical and/or developmental disabilities without regard for service delivery mechanism.

## **Waiver Authority Sought**

EOHHS seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope, in order to offer a peer specialist benefit to only certain individuals and to offer these services in the most cost-effective setting.

## **Rationale**

Mental health professionals have identified peers as a means to reconnect addiction, mental health treatment, and wellness with the recovery/health process. The peer is not a sponsor, case manager, or a therapist, but rather a role model, mentor, advocate, and motivator. By emphasizing long-term recovery, wellness, self-advocacy, socialization, development of natural supports, preventing relapse, and connectedness to one's community this benefit seeks to improve beneficiaries' health and reduce overall health care costs by minimizing ED visits and hospital readmissions, and delaying the onset of other chronic illnesses and conditions requiring Medicaid-funded long-term care.

The State already has a credentialing system in place that ensures that PRS involved with beneficiaries in recovery are qualified and appropriately trained. This will ensure there is adequate access to PRS service providers available to meet the growing demand across Medicaid beneficiaries. All PRS participating in Medicaid must be credentialed by the Rhode Island Board for Certification of Chemical Dependency Professionals (RIBCCDP).<sup>i</sup> RIBCCDP credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC).

This request aligns with the waiver extension's guiding principle of ensuring Medicaid-financed services are responsive and appropriate to a person's medical, functional, and social needs.

## **Waiver Request Item: Rhode Island Clubhouses**

### **Background**

The State proposes to amend the Section 1115 waiver to authorize "clubhouses" as Medicaid service. Clubhouses are local community centers that provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education and housing. The Clubhouse International Model has been recognized by the federal government (SAMHSA) as an evidence-based practice for those with severe and persistent mental illness. For example, the Clubhouse service model has been used to establish to build and enhance a variety of skills important for optimizing health:

- A work-ordered day in which the talents and abilities of members are recognized and utilized within the Clubhouse;
- Participation in consensus-based decision making regarding all important matters relating to the running of the Clubhouse;

- Opportunities to obtain paid employment in the local labor market through a Clubhouse-created Transitional Employment Program. In addition, members participate in Clubhouse supported and independent programs;
- Assistance in accessing community-based educational resources;
- Access to crisis intervention services when needed;
- Evening/weekend social and recreational events; and
- Assistance in securing and sustaining safe, decent, and affordable housing\*

One of the specific goals for those attending a Clubhouse is employment. Clubhouses within Rhode Island will pursue this goal using the principles of the Individual Placement and Support (IPS) model. Specifically, IPS focuses on-going work-based assessments in the community, individualized rapid search for gainful employment, individualized job search, diversity of jobs developed, all job experiences are viewed positively as part of the recovery process, competitive jobs prioritized, follow-along supports, community based services, and assertive engagement and outreach.

Staff in each Clubhouse will have access to the Employment Certification offered and funded by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), to further enhance employment opportunities. Peer specialist and peer mentoring inherent in the Clubhouse model and will also provide the support necessary to encourage recovery, employment, and community based integration.

The goal of providing Clubhouse services is to achieve specific targets tied to improved health outcomes for Medicaid participants. Clubhouses will therefore have to meet certain organizational standards (e.g., staffing, functional duties, reporting etc.) while, at the same time, implement performance goals ensure participants are striving toward concrete outcomes. The State expects, for example, that a Clubhouse will be open at least five days a week and maintain a trained staff qualified to implement Clubhouse International Standards and IPS principles. The On the beneficiary side, the State will require that 100% of all participating beneficiaries develop and follow a person-centered plan containing recovery language that connects to employment goals.

- 1) In addition, we expect that continuous progress toward employment goals for each individual and Clubhouse wide: minimum of 12.5% of the participants will have started Supported Employment/Independent Employment (SE/IE) jobs in the prior 12 months (including jobs that the member no longer has), with at least half of these being 15 hours a week or more.

### **Target Population**

Adult Medicaid beneficiaries with behavioral health care needs regardless of service delivery mechanism.

### **Waiver Authority Sought**

EOHHS seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope, in order to offer a peer specialist benefit to only certain individuals and to offer these services in the most cost-effective setting.

### **Rationale**

The Clubhouses International Model has been implemented in states across the nation and has been proven to a cost-effective service option for people with serious behavioral health conditions, including substance abuse and certain mental illnesses. The Clubhouse International Model has been recognized by the federal government (SAMHSA) as an evidence-based best practice and has the potential to provide an array of educational, employment and housing services that are essential for achieving and maintaining health and wellness.

### **Waiver Request Item: Wellness Benefit – Rhode to Wellness**

Recent empirical evidence has demonstrated that access to preventive care and opportunities for wellness improvement can have both short- and long-term positive impacts on health outcomes. Medicaid programs have increasingly emphasized prevention and wellness to improve beneficiaries' health and reduce overall health care costs.

This wellness benefit will focus on individuals with certain chronic conditions, who receive primary care from a Patient-Centered Medical Home (PCMH). Involvement from and monitoring by the primary care provider (PCP) is critical to the members' ability to succeed in improved wellness. In concert with the members' PCP, the state's contracted Managed Care Organizations (MCOs) or Connect Care Choice programs for Medicaid's fee-for-service population will identify individuals who would benefit from enrollment in the Rhode to Wellness program. Eligibility for referral to this program will consist of the presence of one or more chronic conditions, as well as the willingness of the member to seek alternative approaches to managing their chronic condition. Medicaid's Rhode to Wellness program will be managed by a licensed registered nurse or licensed nurse practitioner. Aspects of the program will include:

- Enrollment in self-management classes for asthma, diabetes, etc. (aligning with the Dept. of Health's Chronic Disease Self-Management Programs).
- Weight Management classes (e.g. Weight Watchers®).
- Exercise and Fitness programs.
- Nutritional counseling.
- Integrated pain management, where appropriate.
- Tobacco cessation.



- Assistance with making and keeping necessary preventive health visits (e.g. annual physical exam, cervical exam for women, etc.).

Members who participate in the Rhode to Wellness program may receive rewards for ongoing participation and goal attainment, in the form of gift cards, at a designated intervals and when certain milestones are achieved. EOHHS will work with its' Medical Care Advisory Committee to refine the Rhode to Wellness program and to develop criteria for identifying eligible beneficiaries to refer to the program.

### **Waiver Authority Sought**

EOHHS seeks a waiver of Section 1902(a)(10)(B), amount duration and scope, in order to offer a wellness benefit to only certain individuals and to offer these services in the most cost-effective setting.

This waiver request modifies paragraph 64 of the current STCs called Health Choice Accounts. The state requests to continue this current authority in a modified format, including the authority to establish a wellness program based on incentives.

### **Rationale**

By emphasizing prevention and wellness, these alternative benefits seek to improve beneficiaries' health and reduce overall health care costs through prevention and wellness activities. This request aligns with the waiver extension's guiding principle of ensuring Medicaid-financed services are responsive and appropriate to a person's medical, functional, and social needs.

Rhode Island also requests the ability to pursue this effort in conjunction with a Health Homes State Plan Amendment authority.

## **Waiver Request: Health Begins with a Home Initiative—Home and Health Stabilization Services**

### **Overview**

There is a growing body of empirical evidence showing that the loss or absence of a “home” has adverse health effects, particularly for vulnerable populations who are at risk for, or coping with, serious physical and/or behavioral health conditions. The term “home” as it is used here, does not refer to a physical space per se, but to a *stable living arrangement* in a supportive community setting rather than in shelter, an institution, “congregate,” temporary housing. Another relevant factor in adverse health effects is a lack of a sense of permanence. As such, we are also referring here to individuals who stay intermittently in the homes of various family members and/or friends (so called “couch surfing”); and/or who have lost and can no longer return to a stable home setting when transitioning from residential treatment, institutional care-settings, other out of home living arrangements, military service, or incarceration.

The purpose of the state’s Health Begins with a Home Initiative (HBHI) is to make an organized set of Medicaid-funded health and home-stabilization services available to members of certain subpopulations through care “collaboratives.” Toward this end, the Executive Office of Health and Human Services (EOHHS) will use the authorities requested under the Section 1115 waiver to implement a system of care collaboratives centered on the premise that “health begins with a home” in conjunction with its partner state and community agencies. This innovative home and health stabilization program targets Medicaid beneficiaries who have complex medical and/or behavioral health conditions and are either homeless or at risk for homelessness or transitioning from high-cost intensive care settings back into the community. The HBHI builds on the state’s past success in implementing person-centered communities of care (COC) for adult Medicaid beneficiaries tailored to meet the needs of a subset of high cost health care utilizers. The COC is implemented as a hybrid benefit that incorporates the intensive, individualized planning of a high-fidelity wrap with the care coordination and service delivery of an assertive community treatment team. The state intends to use a similar care model for the HBHI as it can be readily adapted to the differing health and home stabilization needs of each of the target subpopulations. The chief difference will be the development of care collaboratives composed of a range of providers that have the capacity to develop and implement high-quality care plans and the expertise and access to see them through.

Although there will be variations based on beneficiary needs, the range of services the state plans to make available to HBHI participants will be broad enough to include intensive case management and community-based care coordination as well as both more traditional home stabilization interventions (e.g., a locating a home, managing a household, entitlement support and financial counseling, independent living skill training, safety training, homemaking, etc.) and critical health service supports (e.g., disease and medication management, peer mentoring, family therapy, substance abuse counseling, recovery readiness and relapse prevention, self-care, etc.). To maximize the effectiveness of the HBHI, the state intends to integrate into the care collaboratives the mix of existing State Plan, waiver, and other publicly funded services that enhance home and health stability for each of the targeted subpopulations (e.g., home-based

therapy, day services, employment supports, core home and community-based services such as transition assistance, home modifications, and the like).

HBHI treats home stabilization as a core *primary* care service that affects both the efficacy of health and human services interventions across systems and programs. The state is aware that there are several initiatives funded by CMS and other federal agencies that are designed to expand health services for the Medicaid beneficiaries without or transitioning to a home through various integrated care initiatives, Medicaid waivers, and health homes models. The focus of these efforts tends to be either on health or home stability rather than the interconnection between the two, however. Thus, the state believes that HBHI will demonstrate that home and health stabilization services provided through Section 1115 waiver authorities are an effective intervention that improves health outcomes, reduces costs, and promotes responsibility and independence in the targeted populations.

#### HBHI Target Groups

The HBHI focuses on the following Medicaid beneficiaries:

Target Group #1 -- Medicaid-eligible children and youth with behavioral health needs in the custody of the RI Department of Children, Youth, and Families (DCYF) who are at risk for or transitioning from institutionally based or residential treatment facilities, or congregate care; and the parent(s)/caretaker(s) of these children living in the community.

Target Group #2 -- Medicaid-eligible adults between the ages of 19 and 64 with serious behavioral health or physical conditions who are homeless or at risk of homelessness subsequent to military service, health treatment, or incarceration. Includes youth and adults in this age group who:

- Are homeless or meet the criteria defining at risk of homelessness, as established in federal law under section 725(2) of the McKinney-Vento Homeless Assistance Act and/or other applicable federal and state laws, who have repeated contact with RI Emergency Rooms AND either substance abuse treatment facilities or inpatient psychiatric hospitals; or
- Have been discharged from the U.S. military and are ineligible for federal Veteran's Administration benefits; or
- Have served time in a correctional facility or are on parole and have been identified by the RI Department of Corrections as having a history of complex behavioral health issues including, but not limited to, contact with RI Emergency Rooms, forensic unit stays, intensive psychiatric treatment, and/or substance abuse treatment.

Target Group #3 -- Persons with disabilities and elders who are at risk for or transitioning from institutionally-based care. Includes Medicaid beneficiaries who do not qualify for the state's Money Follows the Person (MFP) demonstration but require long-term restorative interventions and support to remain in the community.

### HBHI Services

The state proposes to provide a wide range of narrowly focused services to HBHI participants. These services will be evidence-based and informed and provided on an individualized basis to correspond to a beneficiary's needs. HBHI services are designed to supplement and enhance, rather than substitute for or supplant, existing federally-funded services available to each of the target groups. Proposed HBHI services include, but are not limited to, the following:

- Comprehensive assessment and care planning through a multi-disciplinary team using a high fidelity approach – e.g., Wraparound in accordance with National Wraparound Principles, or ACT.
- Intensive in-home services including, but not limited to, functional assessments and treatment planning, individualized intervention, transition support.
- Mobile crisis response including immediate and continued interventions to ensure stabilization in the home or community setting, de-escalation and crisis prevention strategies, short-term in-home therapy, behavioral management and support, skills training on coping and activities of daily living.
- Respite services for caretakers
- Peer support and mentoring
- Health literacy and skills including medication management/monitoring, substance abuse identification and prevention, disease self-management
- Entitlement assistance including benefits counseling and system navigation
- Customized goods and services including, but not limited to, home search, tenancy supports, and home modifications and adaptive devices.
- Independent living training including household management and maintenance, job skills training, education supports,
- Domestic violence and drug and sex trafficking intervention, assistance, and prevention
- Support group/self-determination/life satisfaction,
- Individual and group counseling, reengagement, and discharge planning

### Service Delivery and Payment

The initial HBHI delivery and payment mechanisms may vary depending on the target population. For example, HIBI services for Target Group #1 will be provided through care collaboratives that include the Medicaid health plans and the DCYF system of care, as well as community providers experienced in home stabilization. Most of these community providers do not currently participate in the Medicaid program on their own, but would meet the requirements for provider certification as part of such a collaborative. Similarly, the HBHI services provided to Target Group #2 may be delivered through collaboratives created contractually by the Medicaid health plans and may include a more diverse set of community providers –e.g., expertise in homelessness, veterans at risk, youth in transition, etc.

The state proposes to develop a payment methodology that rewards stabilization services that enhance the independence of beneficiaries. As such, the state plans to use its waiver authority to limit the duration of HBHI services (e.g., no more than three years) and provide financial incentives for achieving the desired outcome for beneficiaries – a level of health and home stability in which HBHI services are no longer required.

### **Waiver Authority Sought**

EOHHS is requesting a waiver of comparability and expenditure authority in order to provide HBHI services to members of the subpopulations that have the required level of need. EOHHS also seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope in order to: (1) offer alternative services to members of the target groups and in the most cost-effective setting, (e.g. a person's residence), (2) set limits on the scope and duration of these alternative services – in accordance with evidence-based practices; and (3) develop and implement payment strategies that promote quality outcomes. The State of Rhode Island also requests the authority to waive Section 1902(a)(23), requiring freedom of choice, and any willing provider requirements to ensure access to expert care collaboratives and enable the state, under Section 1115, to obtain federal matching funds for expenditures for HBHI services provided to the three target subpopulations.

Additionally, the state seeks the authority to provide home and health stabilization services to the otherwise Medicaid ineligible parents/caretakers of children in the target subpopulation, providing income does not exceed 253% of the FPL.

### **Rationale**

Underlying the selection of the diverse set of home and health stabilization interventions, and of the HBHI itself, is evidence-based research on housing first programs, nursing home transitions efforts, child welfare systems of care, and health homes initiatives serving beneficiaries with chronic diseases (e.g., diabetes) or serious behavioral health issues (e.g., addiction).

Convincing housing data indicates that chronic health conditions and homelessness are more effectively addressed once people have been provided with a stable living environment – health outcomes improve, use of ED services drop, and beneficiaries are more likely to comply with plans of care. For example, a study of a housing-first program in Denver found 50% of tenants placed into supportive housing experienced improved health status, 43% had improved mental health outcomes, and 15% reduced substance use (Perlman and Parvensky, 2006)<sup>1</sup>. The evidence from a recent study conducted in Rhode Island is consistent with these findings. The study found that between 2010 and 2012<sup>2</sup>:

- Over 38% (2,308/5,986) of the persons utilizing the homeless shelter system in Rhode Island received Medicaid funded services;
- The total cost of the Medicaid services for the 2,308 homeless individuals-- federal and state -- was \$58,136,486;
- The top 67 utilizers -- or just above 3% -- cost a total of \$9,325,375, or \$139,185 per year;
- The average per person per month cost to Medicaid for the remaining homeless people included in the study was \$4,971, which is 37% higher than the per person per month

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<sup>1</sup> [www.denversroadhome.org/files/FinalDHFCCostStudy\\_1.pdf](http://www.denversroadhome.org/files/FinalDHFCCostStudy_1.pdf)

<sup>2</sup> Materials for the Housing First and Medicaid Costs of Home Instability studies may be obtained by contacting Professor Eric Hirsch at: ehirsch@providence.edu. Information cited was provided in documents distributed at the Governor's Interagency Council on Homelessness, in April of 2013. Data derived from Rhode Island Homeless Management Information System- All people who used an emergency shelter from January 1, 2010 to April 30, 2012. Total number = **5,986**

average expenditure for adults with disabilities in Medicaid who did not utilize the shelter system.

Lending further credence to these findings, a Philadelphia, PA health home for the homeless reports a 72% decrease in Medicaid costs for at risk youth and adult beneficiaries receiving both health supports and home stabilization services.<sup>3</sup>

There is equally compelling data related to MFP activities showing differences in the health and cost of providing community-based services for Medicaid-eligible elders versus adults with chronic disabilities. Elders transition to more stable home-like settings and, at least partially as a result, experience greater health benefits and need less costly care than more transient adults with similar intensive care needs (Irvin 2013). Moreover, the findings of this research make it clear that when these adults, most of whom have both physical and behavioral health disorders, are provided with the home stabilization services available to elders through the MFP, use of primary and preventive services goes up while, at the same time, utilization of high cost Medicaid services like the ED begin to drop.<sup>4</sup> Data looking more narrowly at Medicaid and/or Medicare beneficiaries who are at risk for long-term care indicate that the lack of integrated home and health stabilization services has greatly hindered efforts to divert/transition them from institutional care-settings. Additionally, health outcomes and utilization for members of this subpopulation living in the community vary significantly depending on whether they are provided with stabilization services: a review of the relevant data found that those who received home and health stabilization services – typically through HUD supportive housing -- tended to have fewer hospitalizations and acute, but serious conditions like pneumonia and were generally likely to comply with and benefit from disease self-management regimes.<sup>5</sup>

Similarly, research on children's health shows that there is a strong correlation between home stability and a host of health care problems ranging from substance use disorders to serious mental illnesses and acute trauma, and even asthma.<sup>6</sup> Evaluations of child welfare high fidelity wrap programs has found that integrated home and health stabilization services are mutually reinforcing; severely emotionally disturbed children who are transitioned from residential or congregate care to the community have fewer high cost health episodes when health and home stability is a service focus both prior to and after placement (Bruns and Suter, 2010).<sup>7</sup> Additionally, the integration of these stabilization services has proven to be critical nation-wide in building and maintaining the family support systems children with serious behavioral health care conditions need to thrive in the community-setting. For example, the multi-disciplinary teams that anchor the high fidelity wraparound in Milwaukee identify integrated health and home stabilization services as a critical facet of the program's success.<sup>8</sup>

It is the state's expectation that waiver of comparability to implement the HBHI will yield cost savings and health improvements that meet or exceed the results of these initiatives and similar national trends. Note, however, that though the HBHI contains elements of all these

<sup>3</sup> Wilkins, et al., Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities. Available at: <http://aspe.hhs.gov/daltcp/reports/2012/chrhomls2.shtml>

<sup>4</sup> Irvin, et. al., Money Follows the Person 2012 Annual Evaluation Report: Final Report (October 2013). Available at: [http://www.mathematica-mpr.com/~media/publications/PDFs/health/MFP\\_2012\\_Annual.pdf](http://www.mathematica-mpr.com/~media/publications/PDFs/health/MFP_2012_Annual.pdf)

<sup>5</sup> Lewin Group, "Picture of Housing and Health: Medicare and Medicaid Use Among Older Adults in HUD-Assisted Housing". Available at: <http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.shtml>.

<sup>6</sup> See: <http://www.gatesfoundation.org/What-We-Do/US-Program/Washington-State/Homelessness-and-Family-Stability> and <http://aspe.hhs.gov/hsp/10/homelesschildrenroundtable/index.shtml>

<sup>7</sup> Bruns, E. J., & Suter, J. C. (2010). Summary of the wraparound evidence base. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: NationalWraparound Initiative.

care models, it does not fall neatly in to just any one. The state plans instead to establish a care model with the capacity to deliver coordinated health and home stabilization services at the crucial points where they intersect for Medicaid beneficiaries with high cost intensive care needs who might otherwise not thrive in the community. In some instances, HBHI services will be administered in accordance with the guiding principles of a high fidelity wraparound; in other instances, through ACT or similar multidisciplinary approaches.

In sum, by implementing the HBHI, the state hopes to realize reductions in costly institutionally-based care and medical interventions as well as improvements in health and well-being and in several ways. First, once living in a home, ongoing HBHI supports can be provided to beneficiaries that help prevent future health and home crisis's and ensure thoughtful management of ongoing care. The coordination and management of these secondary interventions over the short-term is expected to optimize wellness and facilitate the transition to independence and stability by gradually reducing intensive care management and ensuring supports for success are in place. Second, HBHI services will also enhance beneficiary education, training and employment opportunities and family stability, and in ways that should reduce reliance on all publicly funded services not just health care. From a Medicaid perspective, HBHI services offer significant cost-savings opportunities. The available data show that stabilization services reduce health care expenditures on emergency room care and hospitalizations and prevent the need for treatment in higher cost settings. And third, the HBHI care collaboratives model aligns both the triple aim and the state's long-standing commitment to ensure that Medicaid-financed services are responsive and appropriate given a person's medical, functional and social needs.

## Waiver Request Item: Healthy Works

### **Overview**

The Healthy Works Initiative (HWI) is designed to provide a package of work-related services and supports to adults, up to the age of 64, who are at risk for developing or living with chronic and/or disabling conditions. The HWI is based upon evidence-based research showing that people with steady “meaningful” jobs are healthier contributing members of society. As a recent CMCS Informational Bulletin makes the point:

Work is a fundamental part of adult life for people *with and without* disabilities...*Meaningful* work has also been associated with positive physical and mental health benefits and is a part of building a healthy lifestyle as a contributing member of society.<sup>9</sup>

Although the state has long recognized the important nexus between work and good health, the HWI is a component of a broader-based effort to expand the employment opportunities for Medicaid beneficiaries with chronic conditions and disabilities and to integrate meaningful work into the care planning process.<sup>10</sup> “Meaningful” work, as defined for the purposes of this initiative, is a job in which participants not only have access to the health and work services and supports they need, but they must also earn at least the minimum wage. As it is not clear which comes first – stable employment or good health – the Healthy Works Initiative will focus narrowly on the relationship between work and health from both sides: health issues that are an obstacle to stable employment will be addressed as will employment problems that adversely affect health.

### **Target Groups**

Healthy Works target groups:

- Target Group #1 – Medicaid-eligible adults up to the age of 64 who are living with disabilities<sup>11</sup> or who have been diagnosed with a chronic illness or condition; and
- Target Group #2 – Adults up to age 64 who are receiving Medicaid-funded long-term services and supports in a home or community-based setting.

HWI will use the authority available under Sections 1915(c)(5)(C) and 1915(i) of the Social Security Act, to provide a set of expanded supported employment, prevocational, and habilitative

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<sup>9</sup> Emphasis added.

<sup>10</sup> Many aspects of this effort are outlined in the Consent Decree and Interim Settlement Agreement resulting from Case Number CA-14-175, *The United States v. State of Rhode Island and City of Providence*, No. 1:13-cv-00442(D.R.I July 11, 2013). Available at: <http://www.ada.gov/olmstead/documents/ri-olmstead-statewide-agreement.pdf>.

<sup>11</sup> Persons with developmental disabilities in this group were identified as a “target population” in the Consent Decree noted above and are, as such a priority population. *Ibid.*, 5.



services that build on or fill in the gaps in the existing menu of supports available to members of the target population under section 110 of the Rehabilitation Act (1973), the applicable provisions of the Individuals with Disabilities Education Act (IDEA), and the Medicaid rehabilitation option.

### **HWI Services**

In Rhode Island, Medicaid-funded employment support efforts for persons with disabilities are typically rehabilitative (i.e., services that address capacity issues but that do not have steady work as an explicit outcome). Healthy Works is designed to augment these efforts. For example, the initiative complements the state's "employment first" policy now being pursued by other agencies under the Executive Office of Health and Human Services (EOHHS) umbrella. The policy was advanced for people with disabilities by the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). As a result of a recent settlement with the US Department of Justice, BHDDH has strengthened and expanded this and other employment-related initiatives for the people the agency serves. Thus, the goal of Healthy Works is to further efforts to make integrated community-based employment a central component of the individualized service plan of Medicaid-eligible people with disabilities and chronic conditions receiving services in the home- and community-based setting.<sup>12</sup>

In keeping with this goal, the state has been mindful of the technical guidance provided in the CMCS Informational Bulletin of September 16, 2011, outlining the scope and limits of Medicaid-funded employment and employment supports for people with disabilities and serious conditions.<sup>13</sup> Therefore, the scope of services will be limited to the following:

A. Case Management – identification of a persons' needs, the development of a plan to address those needs, assistance with accessing the required services, and ongoing support to ensure that the plan is being implemented and is addressing the identified needs.

- *Career Planning and Placement*

Providing assistance to develop realistic career goals and working with participants to identify employment sites that will help to achieve career goals.

- *Customized Employment Services*

An extensive planning phase in which the participants work with case managers to identify their goals, desires, and employment needs. This information is then used to guide their employment searches and negotiate individualized employment relationships with employers.

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<sup>12</sup> *Ibid.* See Consent Decree, pages 9 to 11: <http://www.ada.gov/olmstead/documents/ri-olmstead-statewide-agreement.pdf>.

<sup>13</sup> CMCS Informational Bulletin. Center for Medicaid, CHIP and Survey & Certification (CMCS). *Updates to the §1915 (c) Waiver Instructions and Technical Guide Regarding Employment and Employment Related Services*. Available at: [http://www.ct.gov/dds/lib/dds/community/employment\\_informational\\_bulletin.pdf](http://www.ct.gov/dds/lib/dds/community/employment_informational_bulletin.pdf)

- *Service Coordination*

The case manager collaborates with others providing support and, to extent required, ensure all the necessary workplace and personal services are in place for sustained, successful employment.

B. Prevocational Supports – assist participants in acquiring the skills required to thrive in the workplace.

- *Attendance*

Teach the importance of being present regularly at a place of employment and coordinating efforts to maintain employment.

- *Motor Skills*

Assist in the development of movements that combine to produce a smooth, efficient action in order to master a particular task.

- *Workplace Safety*

Help participants to understand the policies and procedures that are in place to ensure the safety and health of employees within a workplace. This involves hazard identification and ongoing safety training and education for employees.

- *Interview Skills*

Provide participants with the skills to talk to people in an interview situation, answer questions, and understand the right questions to ask a potential employer.

- *Job Search Assistance*

Activities that support and assist each participant in searching for an appropriate job that complements their individual skills, minimizes their limitations, and advances toward their career goals.

- *Job (skill) Training*

Training that improves a participant's ability to do their work—but not a specific task—in a timely, successful manner by focusing on developing the major skills used daily at work (e.g., organizing and managing materials, focusing on specific tasks).

- *Transportation*

Provide access to and from work through transportation services.

C. Health Maintenance and Social Engagement—helping people to maintain their health and engage in positive social interactions in the workplace to ensure overall wellbeing.

- *Targeted Health/Behavioral Health Services*  
Peer supports and/or navigation to guide and reinforce healthy behaviors and engage coworkers.
- *Learning Disability Management*  
Process to prevent a disability from becoming more complex by having an individual fully understand the nature of the disability and what supports will be needed in order to go about day to day employment activities
- *Personal Assistance Services*  
Providing caregiver supports to individuals with limitations that prevent them from performing basic functions of everyday life. These services can be provided in a place of employment.

### **Waiver Authority Requested**

The state proposes to use the full range of habilitative services available under the Section 1915 (i) State Plan option as well as a unique set of incentives and rewards for worker hiring, training, and retention through the state's Section 1115 waiver demonstration. Accordingly, the state is requesting a waiver of section 1902(a)(10)(B), as implemented in 42 CFR 440.240(b) to authorize the state to offer employment support benefits that vary from benefits available under the State Plan to HWI participants.

### **Rationale**

The experience of the states and empirical research provide compelling evidence of the strong relationship between employment stability and good health. Aside from the benefits from income and, in many instances, access to employer-sponsored health insurance, steady work is correlated with an array of positive outcomes including moderating or delaying the onset of chronic diseases, promoting overall wellness, and reducing risky behaviors such as smoking, substance abuse, and obesity related conditions. As a result, people with stable employment are not only often healthier overall, but also less likely to need high cost treatments, interventions and institutionally based services until much later in life if ever. For example, research has consistently shown that TANF participants with an unaddressed health condition "have a significantly lower likelihood of employment."<sup>14</sup>

With the amendments to Section 1915 (i) under the Affordable Care Act, states have had the option to expand employment initiatives under their Medicaid State Plans to people with disabilities who do not have an institutional level of need. The state's goal in the Healthy Works Initiative is to seek the authority in this Section 1115 waiver to pursue the employment initiatives

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<sup>14</sup> Pamela Loprest and Elaine Maag. *Disabilities Among TANF Recipients: Evidence from the the NHIS*. The Urban Institute. Available at: [http://www.urban.org/UploadedPDF/411883\\_disabilitiesamongtanf.pdf](http://www.urban.org/UploadedPDF/411883_disabilitiesamongtanf.pdf)

allowed under both Section 1915(c) and Section 1915(i) for the target population of people with disabilities. From the state's perspective, stable, meaningful employment is essential for both rebalancing the long term care system and implementing Rhode Island's integrated care initiative. The Medicaid expansion to low income adults under the ACA affords Rhode Island the opportunity to extend Medicaid funded work supports a step further. The flexibility and authority available through a Section 1115 demonstration will enable the state to provide a wider range of employment supports to a small group of young adults without regard to health status.

The benefits of the Healthy Works Initiative are multiple and far reaching. The state's long-term goal is to ensure that Rhode Islanders retain their independence and health for as long as possible. Employment for persons with disabilities is important for an individual's self-worth, connection to the community, and income growth. Healthy Works will assure that people with disabilities will have access to the supports necessary to obtain steady work thereby decreasing reliance on more costly services. By providing additional employment supports, there is an increased opportunity for eligible people to not only attain employment, but also to become vital members of the state's economy. Also, HWI will offer the state the opportunity to evaluate whether steady work can assist young adults transition into the workforce and, in doing so, improve health outcomes and shift or divert people from Medicaid and other publicly funded health coverage to private, employer sponsored insurance.

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<sup>i</sup> RIBCCDP standards for Peer Recovery Specialist are:

- Education: High school diploma or equivalency.
- Training: 46 hours of training with 10 hours each in the domains of Advocacy, Mentoring and Education, and Recovery/Wellness Support and 16 hours in the domain of Ethical Responsibility.<sup>i</sup>
- Experience: 500 hours of volunteer or paid work experience specific to the domains.
- Supervision: A total of 25 hours of supervision specific to the domains. Supervision must be provided by an organization's documented and qualified supervisory staff per job description.
- Examination: Applicants must pass the RIBCCDP Peer Recovery Examination.
- Code of Ethics: The applicant must agree, in writing, to abide by the code of ethics.
- Recertification: 20 hours of continuing education earned every 2 years including 6 hours in ethics.